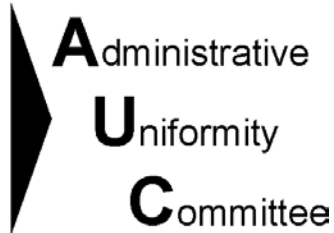


**Meeting Materials**  
**Acknowledgments TAG Meeting**  
**June 2, 2011**

1. Acknowledgments TAG 6\_2\_2011 agenda
2. ACK overview and process flows revised 052411



---

## AUC – Acknowledgments TAG Agenda

June 2, 2011 (8:00-10:00 am, CDT)

[Conference Call / web-ex ONLY!](#)

Conference call number is: 1-213-289-0500 Participant Access Code: 337213

Callers are responsible for any long distance charges to the number above

### WebEx Instructions--

1. Click on this link: <https://health-state-mn-ustraining.webex.com/mw03061/mywebex/default.do?siteurl=health-state-mn-ustraining&service=7>
2. Click on the link to the AUC Acknowledgments TAG meeting.
3. Type your name, email address and password into the prompt boxes. The password is: **Ack2010!**

1. AUC Antitrust Statement
2. Welcome and Introductions
  - a. Take attendance for AUC member organizations
3. ACTION ITEMS:
  - a. Approve Minutes from April 7, 2011 meeting
4. DISCUSSION ITEMS:

Acknowledgment recommended process flow best practice
5. Next Meeting Information:

TBD



**A**Administrative  
**U**niformity  
**C**ommittee

# Acknowledgement Business Purpose

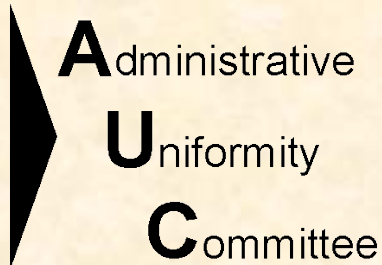
---

- Acknowledgements are used in the exchange of transactions to
  - Report Syntax Errors
  - Report HIPAA TR3 (Guide) Errors
  - Acknowledge Receipt
  - Accept or Reject

**A**dministrative  
**U**niformity  
**C**ommittee

# Minnesota Statutes, section 62J.536


- 
- MS 62J.536, Subd. 1 (e)  
<https://www.revisor.mn.gov/statutes/?id=62J.536>
    - (e) Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction...
  - MS 62J.536, Subd. 4 (a)
    - **Health care clearinghouses.** (a) Beginning January 1, 2012, health care clearinghouses must use and make available suitable tracking mechanisms to allow health care providers and group purchasers to determine in a timely fashion that health care claims or equivalent encounter information transactions and health care payment and remittance advice transactions were delivered to their intended final destination. Clearinghouses must provide clear, understandable, accurate information and instructions for tracking claims and remittance advice transactions to all clients, potential clients, or interested parties...



# Types of Acknowledgements

---

- **Delivery Acknowledgement**
  - TA1 (Interchange Acknowledgment)
    - Explains Envelope Compliance and Acknowledgement
- **Syntax and HIPAA TR3 Response Acknowledgement**
  - 999 (Implementation Acknowledgment)
    - X12 Standard Compliance
    - Implementation Guide Compliance (HIPAA TR3)
- **Business Application Acknowledgement**
  - 277CA (Claims Acknowledgement)
    - Pre-Adjudication Only

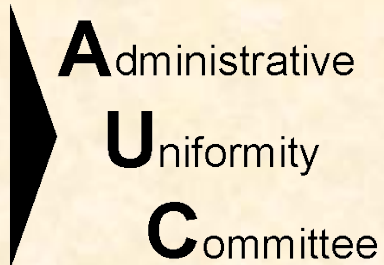


**A**Administrative  
**U**niformity  
**C**ommittee

# TA1 Interchange Business Purpose

---


- The TA1 will be used to report the status of processing a received interchange header and trailer (ISA-IEA). It will either indicate that the interchange is accepted or rejected.
- When a TA1 is received and it rejects
  - You will need to correct and resubmit the entire ISA –IEA Interchange
- The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only.
- The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure. A TA1 can be included in an interchange with other functional groups and transactions.
- The standards state that the TA1 is required to be sent when requested by the sender (as indicated in the ISA14 of the submitted interchange), or when an interchange is rejected.



# TA1 Usage Recommendation

---

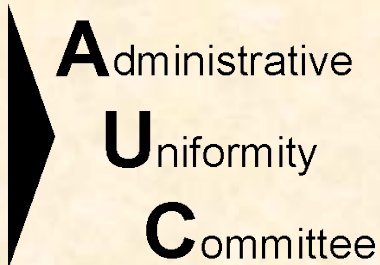
- **This best practice recommends that the receivers only send the TA1 when the interchange is noncompliant and is rejected.**
- **It is recommended that senders of transactions set the ISA14 to zero knowing that a TA1 will arrive if the Interchange is rejected.**
  - When the Interchange is valid the sender will receive an appropriate acknowledgment to verify receipt.

**A**dministrative**U**niformity**C**ommittee

# 999 Business Purpose

---

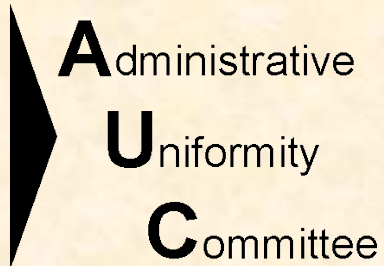
- The 999 replaces the 997 transaction. It is not compliant to use a 997 to acknowledge HIPAA TR3s
  - FORMAL INTERPRETATION from X12
    - For a healthcare TR3 implementation, the 999 transaction must be used. Further guidance as to which transaction is to be used can be found in section 1.3.2 of TR3 005010X230 (997). This TR3 specifically states: This 997 implementation guide can NOT be used for responding to any implementation guideline (TR3).
- The 999 reports the results of the X12 syntactical analysis, plus the results of the HIPAA TR3 semantic analysis
- This 999 implementation guide can NOT be used for any application level validations.
- The ASC X12 999 transaction set is designed to respond to one and only one functional group (i.e. GS/GE), but will respond to all transaction sets (i.e. ST/SE) within that functional group.
- When a 999 has a disposition of “accepted” this means the submitted file has completed syntactical and semantic edits only but does not mean that the file or units of work were accepted for processing



# Types of 999s

---

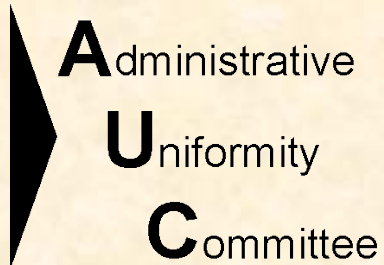
- A = Accepted
- E = Accepted with Errors: The transaction set is accepted but there are errors which are reported in the AK2 loop of the 999. This loop will identify which transactions within a functional group contained errors, but were forwarded for further processing.
- R = Rejected: The transaction set is not accepted and the errors will be reported in the AK2 loop of the 999. This loop will identify which transactions within a functional group contained errors, and will NOT be forwarded for further processing. Corrections will need to be made and the transaction resubmitted.



# 277CA Business Purpose and Recommendation

---

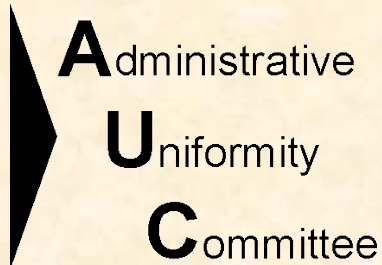
- The 277CA will be used to replace proprietary error reporting.
- Indicates Accepted or Rejected into the adjudication system (not pended).
- It is recommended that the 277CA be created by the receiver of the 837 claim transaction set to acknowledge to the submitter each unit of work (claim or encounter), regardless of whether the unit of work was accepted into the adjudication system or rejected.
- Acknowledgement of other units of work such as a file or transaction set or at the provider level are also accommodated by the 277CA.



# Guiding Principles

---


- A 999 will be sent from a Clearinghouse (CH) to a sender only if the sender uses a v5010 X12 transaction format.
  - There is no way to send a 999 from a CH to a sender if the sender submits another format.
- If a sender continues to send 4010A1 version to a value-added CH for conversion to v5010 after 1/1/2012 (not recommended) the CH may reply with a 997.



# Approach for Error Handling

---

- The TA1 and 999 generally reflect technical problems that must be addressed by changes in the software used in preparing the EDI transmission.
  - “Trouble Tickets” will likely be addressed by technical resources to identify corrections needed before resubmission.
- The 277CA reflects a data problem that must generally be addressed by resources in the Provider office.
  - Provider staff will likely need reports to be produced using the 277CA transaction in order to identify corrections before resubmission.
  - Clearinghouses and Vendors may consider offering a 277CA reporting capability.

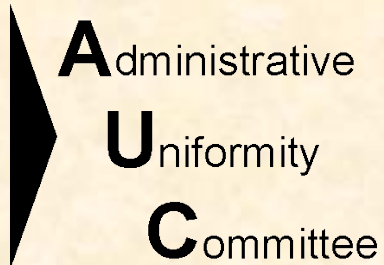


**A**ministrative  
**U**niformity  
**C**ommittee

# Approach for Error Handling

---

- When a 999 (Rejected) is received:
  - Recognize that syntax / guide errors occurred and begin a correct/resubmit action.
- When a 999 (Accepted with Errors) is received:
  - Recognize all transactions were accepted, and know that you had errors so you can fix the problem before your next submittal;
  - Watch for additional acknowledgment detail on the 277CA.
- The receiver of a 999 does not respond with another 999 acknowledgement.
- When a 277CA is received:
  - Recognize that business rule errors occurred and begin a correct/resubmit action on specific units of work;
  - Recognize that each claim level (CLM) unit was either accepted or rejected;
  - You may receive a claim number (ICN) in the REF (1K) segment that is to be used in future claims inquiries.
- It is recommended that a receiver of a 277CA send a 999.

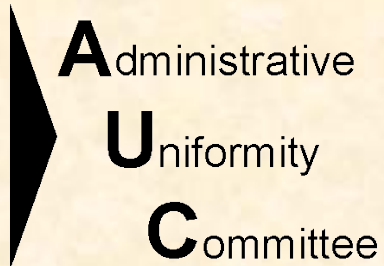


# Claims (837)

## Slide Summary

---

- Slide 14: Provider to Payer (X12) – Errors on First and Second Transaction
- Slide 15: Provider to Payer (X12) – Errors on First Transaction But Not Second Transaction
- Slide 16: Provider to Payer (X12) – No Errors
- Slide 17: Provider to CH (proprietary), CH to Payer ( X12) – No Errors
- Slide 18: Provider to CH (proprietary), CH to Payer (X12) – Accepted with Errors
- Slide 19: Provider to CH, CH to Payer (X12) – Accepted with Errors
- Slide 20: Provider to CH (proprietary), CH to CH (X12), CH to Payer (X12) – No Errors



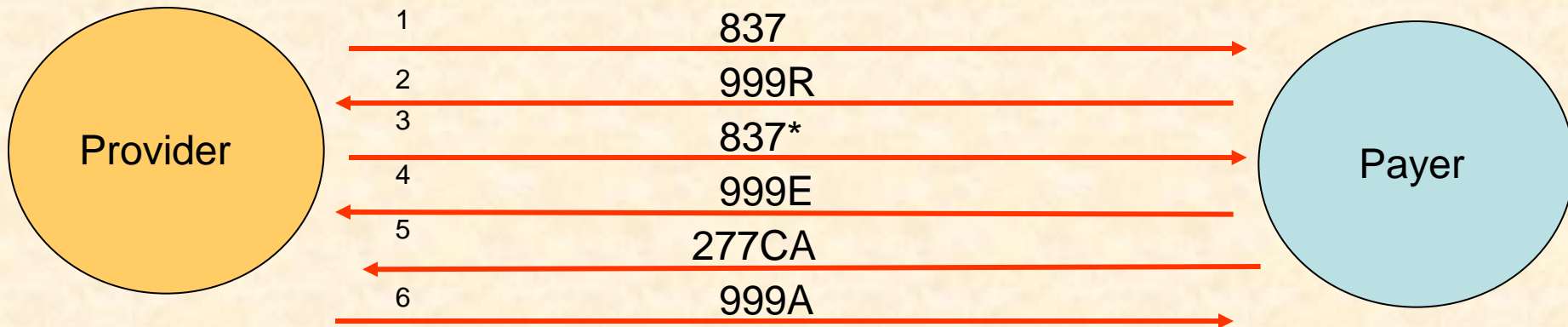
# Introduction to Best Practice Scenarios

---

- The following scenarios do not depict all flows or acknowledgments that may occur in the exchange of transactions.
- The intent of the depicted flows is to provide a best practice model to be used when planning your acknowledgment process.

**A**dministrative  
**U**niformity  
**C**ommittee

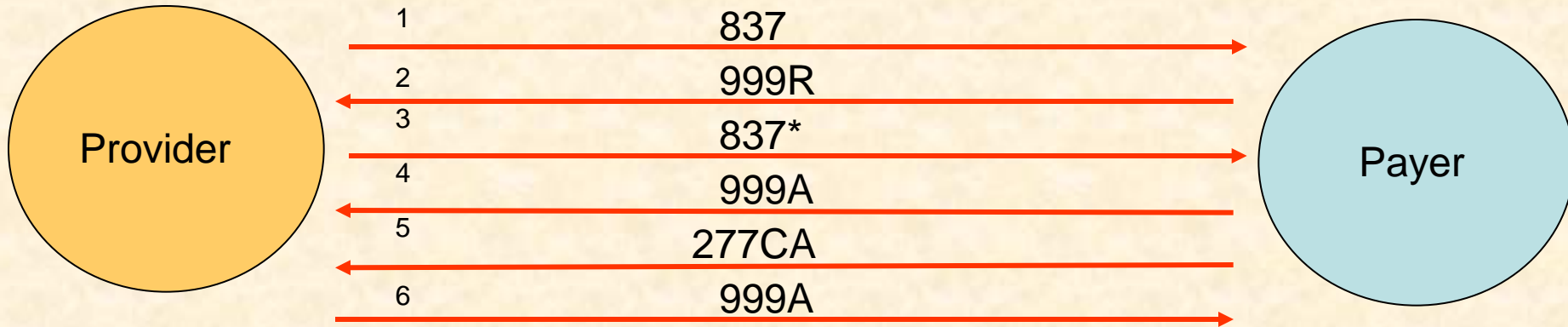
# Claims: Provider to Payer (X12) – Errors on First and Second Transactions



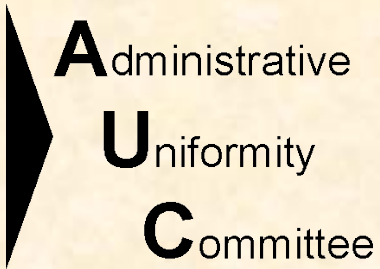
\* -- Represents that provider has corrected and resubmitted transaction. However, there are still errors on the second transaction.

**A**dministrative  
**U**niformity  
**C**ommittee

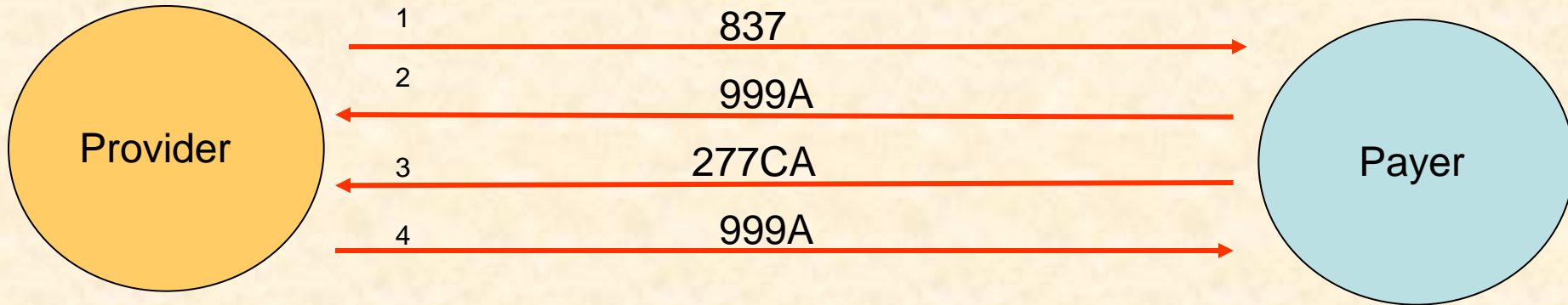
# Claims: Provider to Payer (X12) – Errors on First Transaction But Not Second Transaction



\* -- Represents that provider has corrected transaction errors and has resubmitted the transaction.

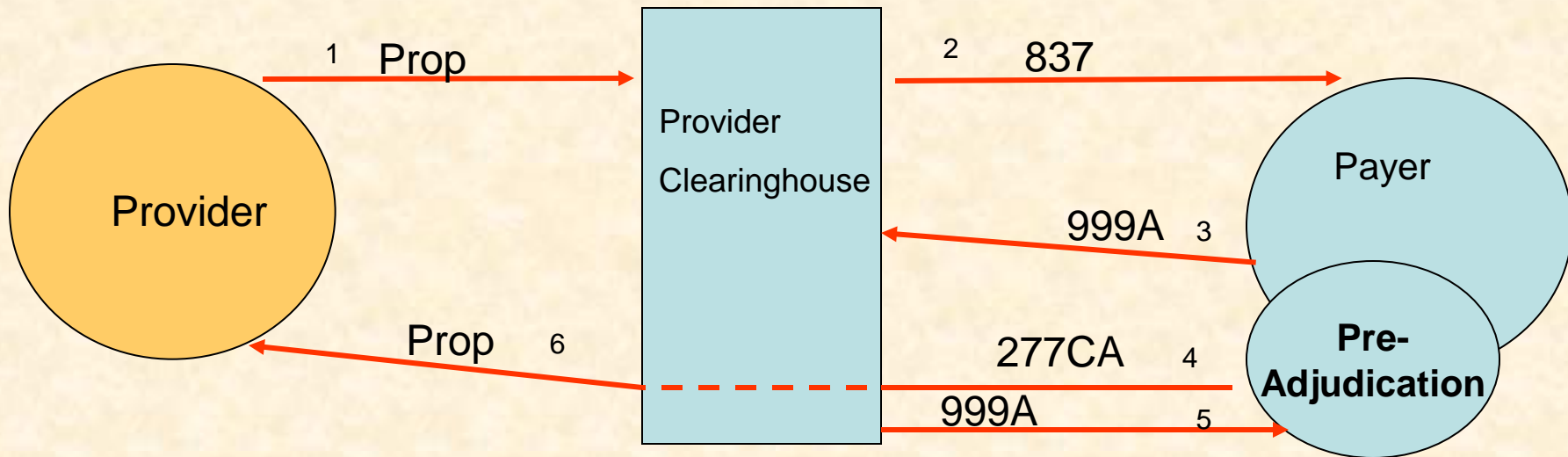


# Claims: Provider to Payer (X12) – No Errors



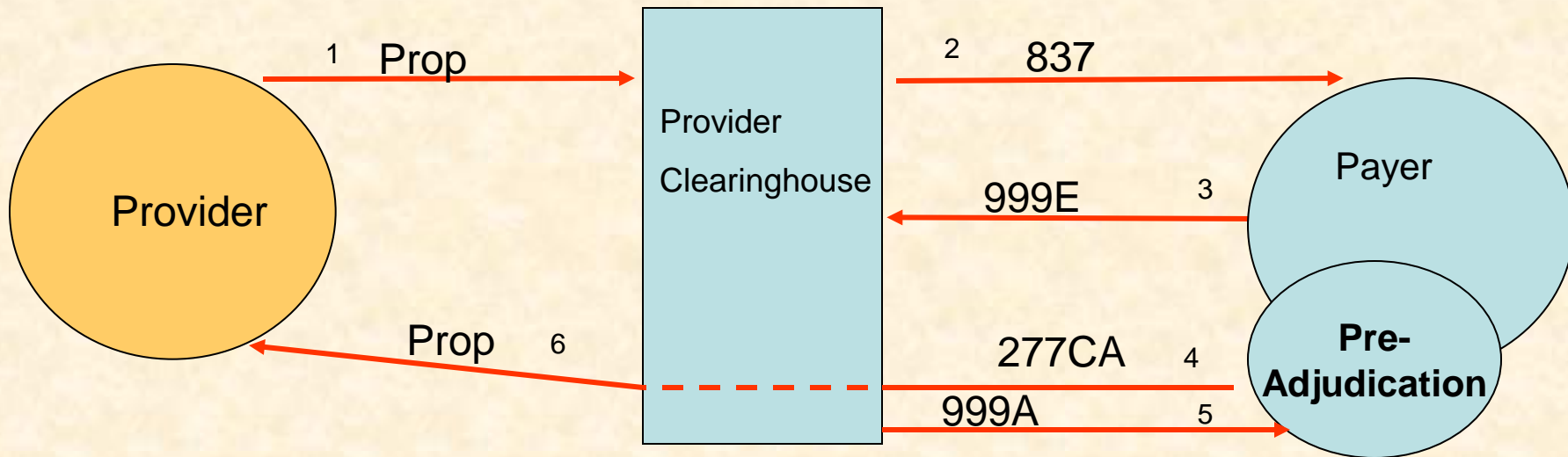
**A** Administrative  
**U** niformity  
**C** ommittee

# Claims: Provider to CH (proprietary) CH to Payer (X12) - No Errors

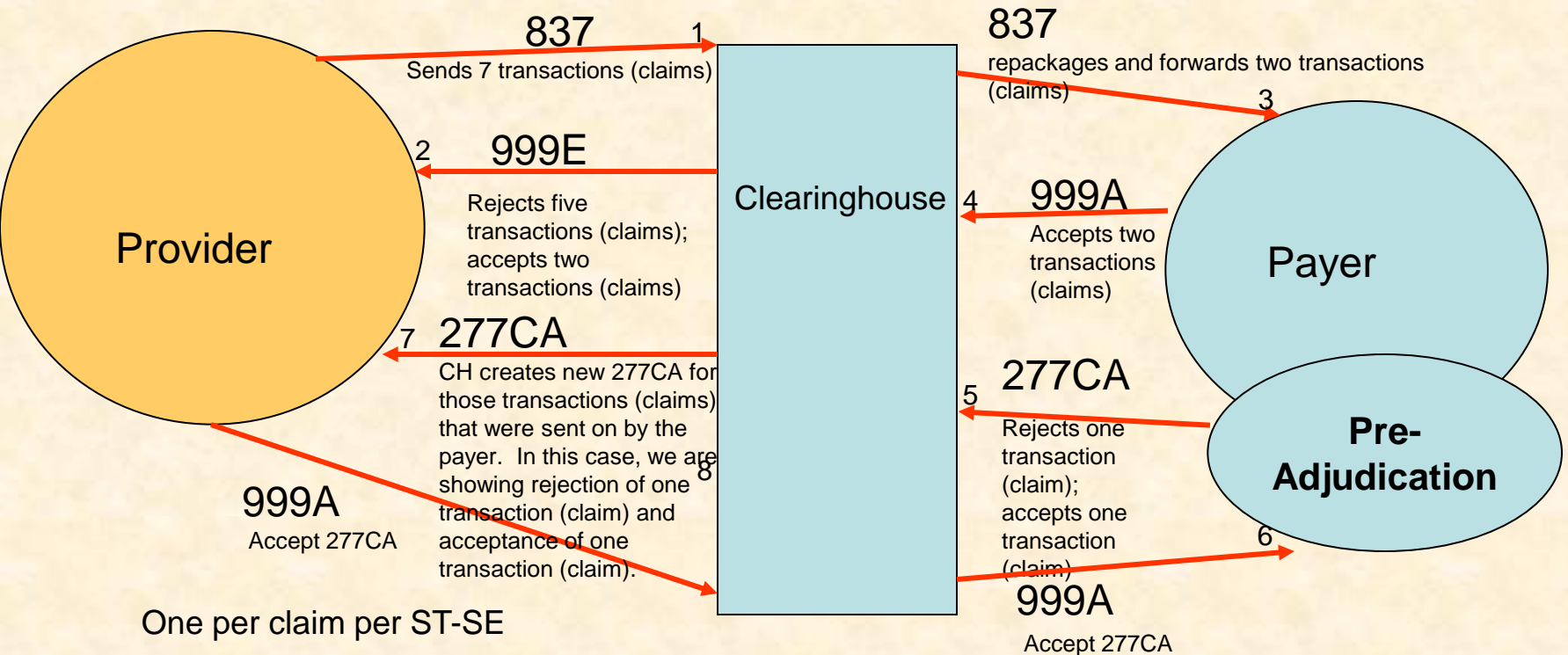


**A**dministrative  
**U**niformity  
**C**ommittee

# Claims: Provider to CH (proprietary) CH to Payer (X12) - Accepted with Errors



# Claims: Provider to CH CH to Payer (X12) – With Errors



Step 3 -if the transaction file had only one unique billing NPI in all the claims then the CH would package all those claims into one ST-SE. The CH creates a separate ST-SE for each billing NPI.

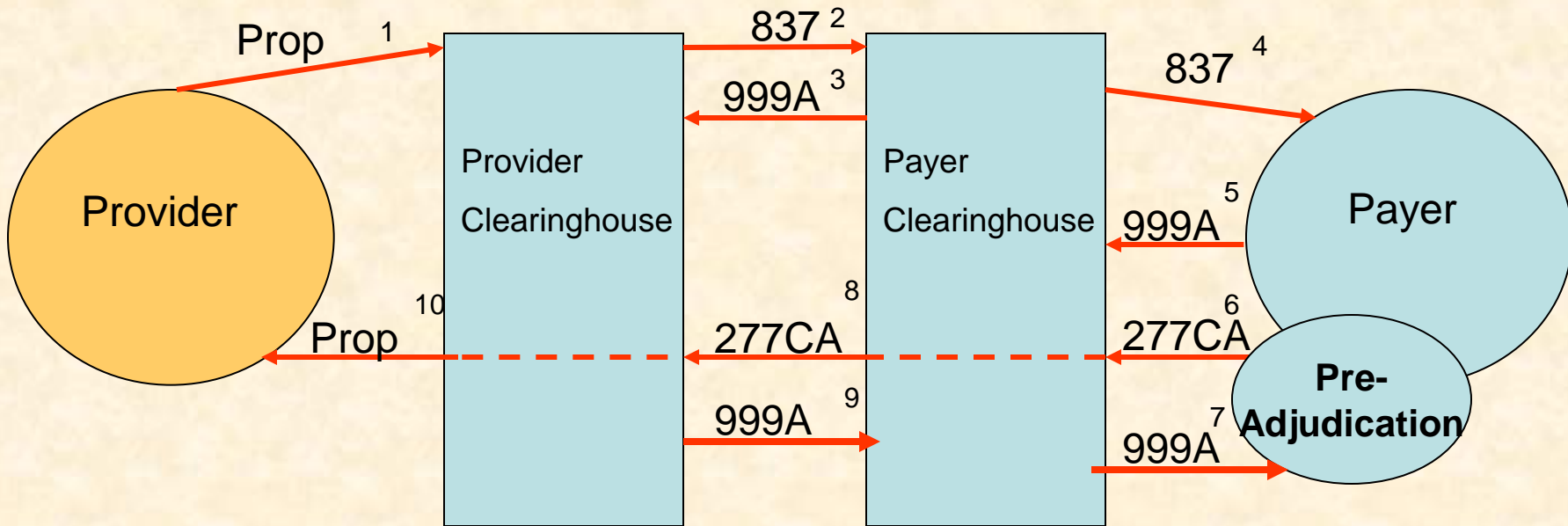
Steps 5 and 7 – In the example above, the two claims were packaged into one 277CA transaction.

In the above example, the original 837 was submitted with one claim in each transaction.

Discussion item to vet: Best Practice recommend TRN02 in step 7 be mapped to original BHT03 value of orig 837 in step 1.

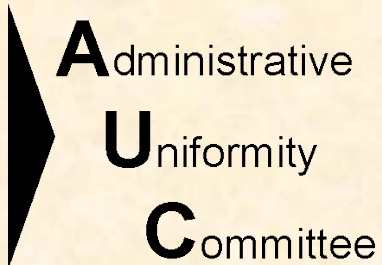
**A**dministrative  
**U**niformity  
**C**ommittee

**Claims: Provider to CH (proprietary)**  
**CH to CH (X12)**  
**CH to Payer (X12) – No Errors**



One of the more common flows. It is expected this flow will occur most often since it indicates there are no errors in any files.

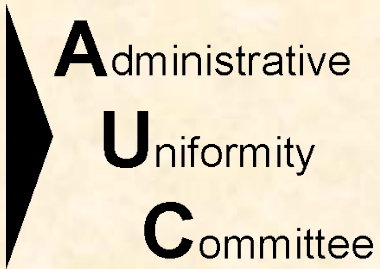
Note: change this slide to show just the case of payer doing its own pre-adjudication; addl input on slide from small group



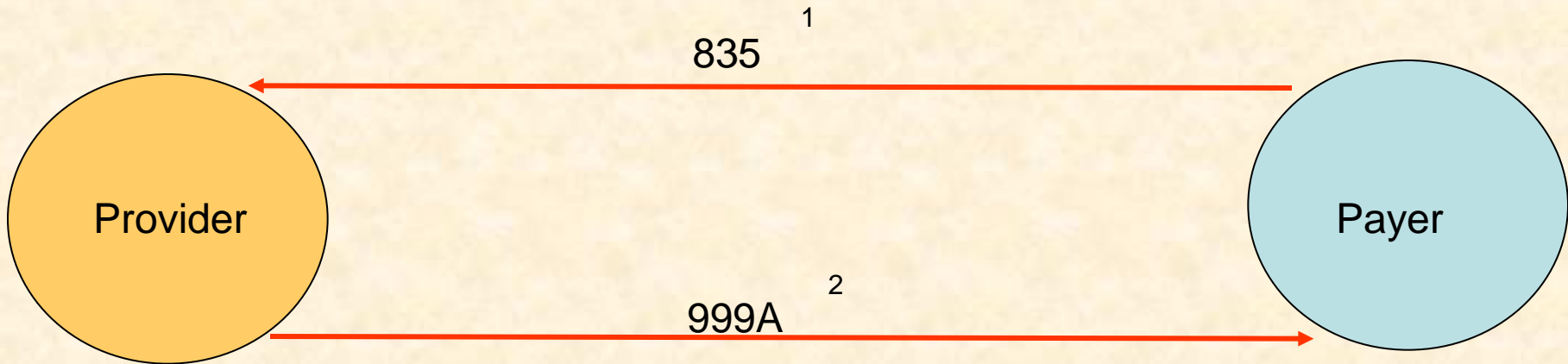
# Remittances (835) Slide Summary

---

- Slide 24: Payer to Provider – No Errors
- Slide 25: Payer to Provider – Accepted with Errors
- Slide 26: Payer to Provider – Reject Interchange
- Slide 27: Payer Provider – Reject Transaction
- Slide 28: Payer to Payer CH to Provider
- Slide 29: Payer to Payer CH to Provider CH to Provider  
– No errors
- Slide 30: Payer to Provider CH to Provider (proprietary).

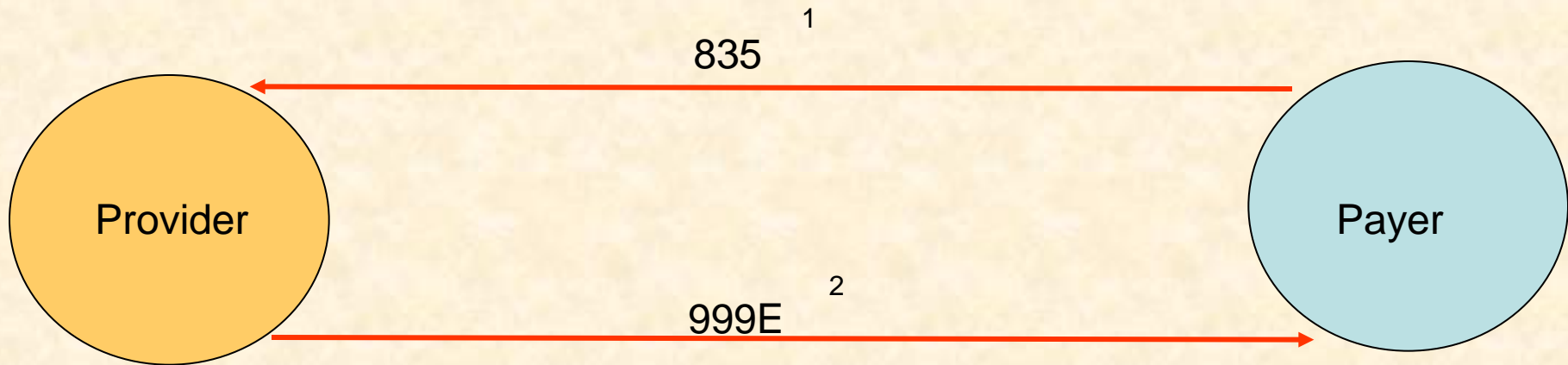


# Remittance: Payer to Provider – No Errors



**A**dministrative  
**U**niformity  
**C**ommittee

# Remittance: Payer to Provider – Accepted with Errors

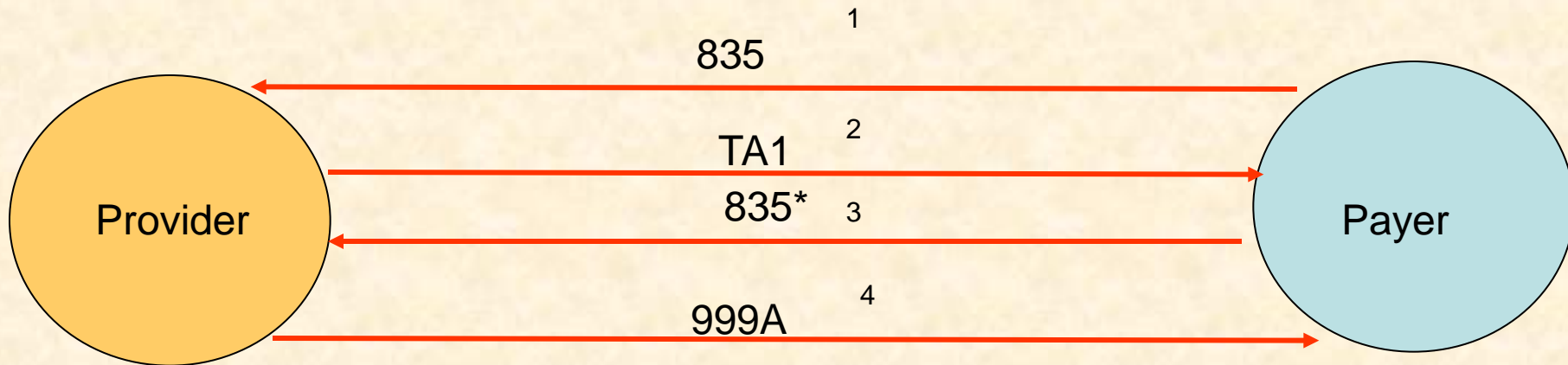


**A**dministrative

**U**niformity

**C**ommittee

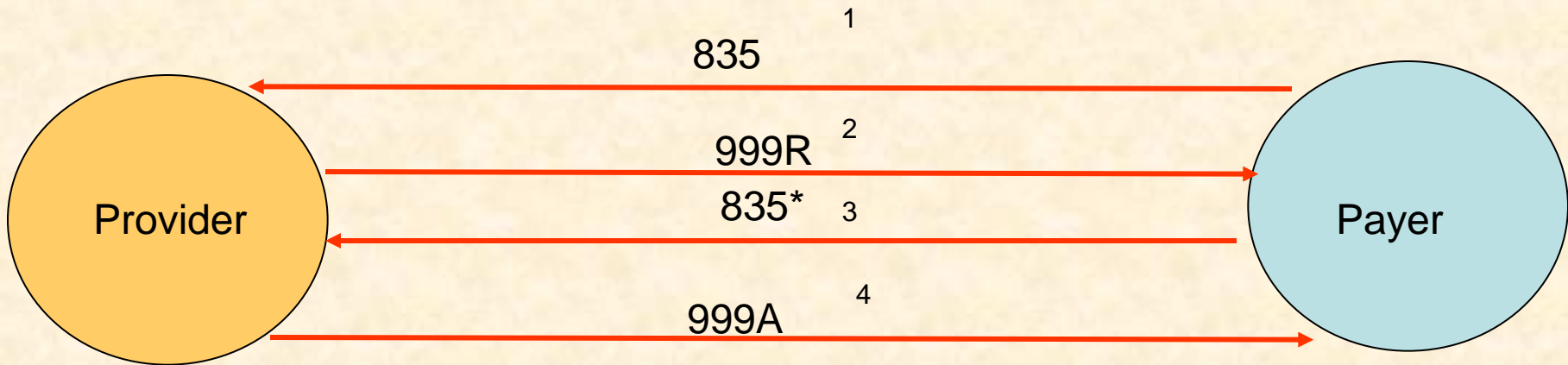
## Remittance: Payer to Provider – Reject Interchange



Note: This slide provides an example of one instance of a problem at the interchange and reported back on the TA1.

\* -- Represents that the payer has corrected and resubmitted transaction.

# Remittance: Payer to Provider – Reject Transaction



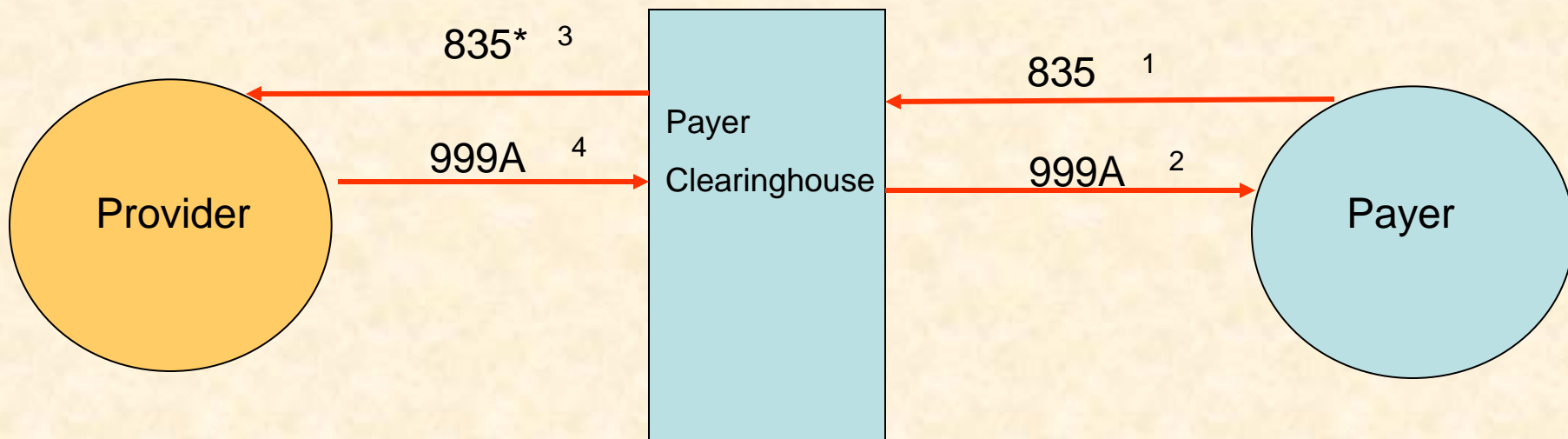
\* -- Represents that the payer has corrected and resubmitted transaction

**A**dministrative

**U**niformity

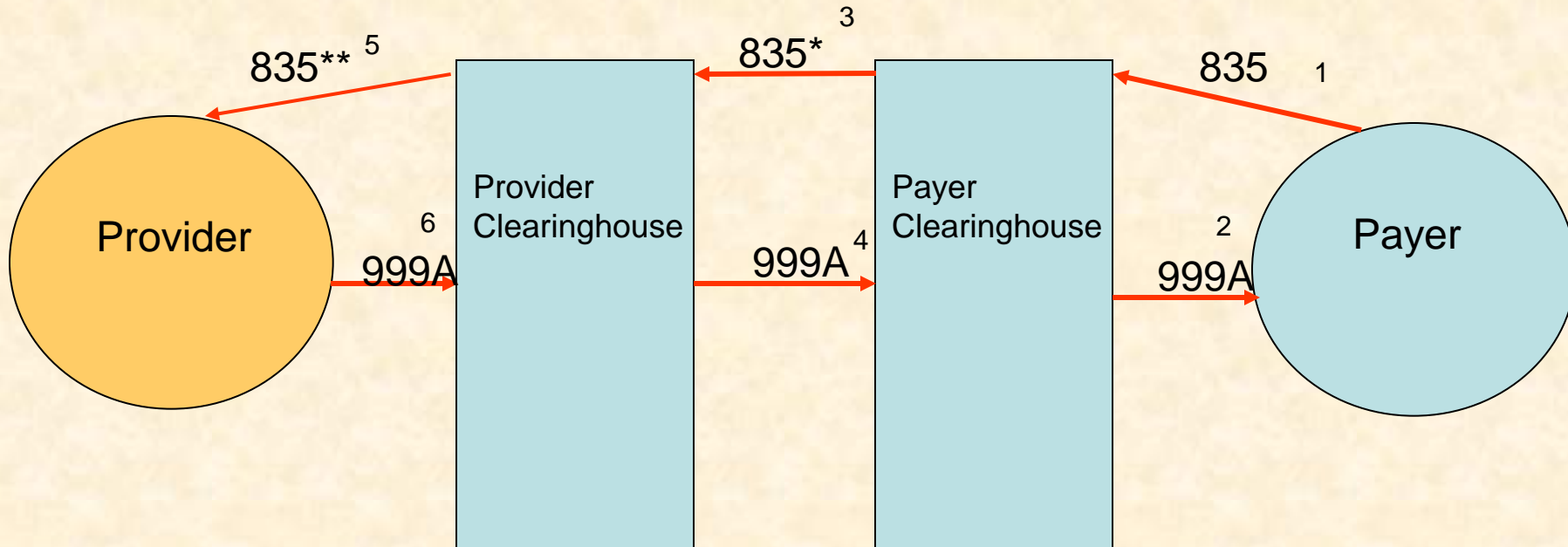
**C**ommittee

# Remittance: Payer to Payer CH to Provider



\* -- Represents the 835 data received from the payer, re-enveloped and sent to the provider.

# Remittance: Payer to Payer CH to Provider CH to Provider



\* -- Represents the 835 data received from the payer, re-enveloped and sent to the provider's clearinghouse.

\*\* -- Represents the 835 data received from the provider's clearinghouse, re-enveloped and sent to the provider.

**A**dministrative  
**U**niformity  
**C**ommittee

# Remittance: Payer to Provider CH to Provider

